


<b>Rheumatology Referral Form</b>	<b>Y Medical Associates</b> Fax: 855-838-0623 Phone: 800-447-7558	
Date: _____		

Patient Information	Prescriber Information
Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Cell Phone: _____ DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA: _____ NPI #: _____ Contact Person: _____

Insurance Information		
Primary Insurance: _____	ID#: _____	Group: _____
Secondary Insurance: _____	ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN#: _____ PCN#: _____ Group: _____

**Clinical Information (Please fax all pertinent clinical and lab information)**

M06.9 (Rheumatoid Arthritis)  M08.0 (Juvenile Idiopathic Arthritis)  L40.59 (Psoriatic Arthritis)  L40.54 (Psoriatic Juvenile Arthritis)  
 M45.9 (Ankylosing Spondylitis)  M32.9 (Systemic Lupus Erythematosus)  Other: \_\_\_\_\_  
 Diagnosis Date: \_\_\_\_\_


**Diagnosis and Clinical Assessment (Fill in below or attach lab work)**

Joints Affected: \_\_\_\_\_ Number of Tender Joints: \_\_\_\_\_ CRP: \_\_\_\_\_ Date: \_\_\_\_\_  
 Number of Swollen Joints: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Date: \_\_\_\_\_ ESR: \_\_\_\_\_ Date: \_\_\_\_\_  
 New Therapy Induction | Stop Date: \_\_\_\_\_  Therapy Change | Stop Date: \_\_\_\_\_  
 Therapy Continuation | Stop Date: \_\_\_\_\_  Weeks Completed:  0  2  4  6  
 Allergies: \_\_\_\_\_  
 TB Results & Date (Please provide copy of result): \_\_\_\_\_  
 Bone Density Score & Date (Please provide a copy of results): \_\_\_\_\_

Medication	Dose Strength	Directions	Qty	Refills
Actemra	<input type="checkbox"/> Prefilled Syringe 162mg/0.9mL <input type="checkbox"/> Auto Injector 162mg/0.9mL	<input type="checkbox"/> <100kg Inject 162mg/0.9mL SC every 2 weeks <input type="checkbox"/> >100kg Inject 162mg/0.9mL SC every week		
Benlysta	<input type="checkbox"/> 10mg/kg <input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200mg Autoinjector	<input type="checkbox"/> <b>IV Starter Dose:</b> Infuse 10mg/kg every 2 weeks for 3 doses <input type="checkbox"/> <b>IV Maintenance:</b> Inject 10mg/kg every 4 weeks <input type="checkbox"/> Inject 200mg SC once weekly (if switching from IV administer first SC dose 1-4 weeks after last IV dose)		
Cimzia	<input type="checkbox"/> Starter Kit <input type="checkbox"/> Syringe <input type="checkbox"/> Vial	<input type="checkbox"/> <b>Starter Dose:</b> Inject 400mg SC on week 0, 2, and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 200mg SC every 2 weeks <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 400mg SC once a month		
Cosentyx	<input type="checkbox"/> 150mg Sensoready Pen <input type="checkbox"/> 300mg Sensoready Pen	<input type="checkbox"/> <b>Starter Dose:</b> Inject 150mg SC on week 0, 1, 2, 3, and 4 <input type="checkbox"/> <b>Maintenance:</b> Inject 150mg SC every 4 weeks <input type="checkbox"/> <b>Starter Dose:</b> Inject 300mg SC on week 0, 1, 2, 3, and 4 <input type="checkbox"/> <b>Maintenance:</b> Inject 300mg SC every 4 weeks	<input type="checkbox"/> 5 <input type="checkbox"/> 1 <input type="checkbox"/> 10 <input type="checkbox"/> 2	
Enbrel	<input type="checkbox"/> 25mg Syringe <input type="checkbox"/> 0.25mg Vial <input type="checkbox"/> 50mg Syringe <input type="checkbox"/> 50mg SureClick Pen <input type="checkbox"/> Mini 50mg/mL	<input type="checkbox"/> Inject 50mg SC every week <input type="checkbox"/> Inject _____ mg(0.8mg/kg x _____ kg) SC every week		
Evenity	<input type="checkbox"/> 105mg/1.17mL	<input type="checkbox"/> Inject 2 syringes (105mg each) for total dose of 210mg SQ once monthly	<input type="checkbox"/> 2	
Forteo	<input type="checkbox"/> 600mcg/2.4mL PFS	<input type="checkbox"/> <b>Maintenance:</b> Inject 20mcg SC once daily	<input type="checkbox"/> 1	
<input type="checkbox"/> Humira <input type="checkbox"/> Adalimumab (biosimilar)	<input type="checkbox"/> 10mg Syringe <input type="checkbox"/> 20mg Syringe <input type="checkbox"/> 40mg/0.4mL Syringe <input type="checkbox"/> 40mg/0.4mL Pen	<input type="checkbox"/> Inject 10mg SC every other week (10 to <15kg) <input type="checkbox"/> Inject 20mg SC every other week (15 to <30kg) <input type="checkbox"/> Inject 40mg SC every other week (30kg) <input type="checkbox"/> Inject 40mg SC once weekly		

**Prescriber Signature:** \_\_\_\_\_ **DAW (Dispense as Written)** **Date:** \_\_\_\_\_

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 New Therapy Induction | Stop Date: \_\_\_\_\_  Therapy Change | Stop Date: \_\_\_\_\_  
 Therapy Continuation | Stop Date: \_\_\_\_\_  Weeks Completed:  0  2  4  6  
 Allergies: \_\_\_\_\_  
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 Bone Density Score & Date (Please provide a copy of results): \_\_\_\_\_

Medication	Dose Strength	Directions	Qty	Refills
Kevzara	<input type="checkbox"/> 150mg/1.14mL PFS <input type="checkbox"/> 200mg/1.14mL Pen	<input type="checkbox"/> Inject 200mg SC once every 2 weeks <input type="checkbox"/> Other: _____		
Krystexxa	<input type="checkbox"/> 8mg/mL	<input type="checkbox"/> Infuse 8mg in 250mL of NS over 120 minutes once every 2 weeks		
Olumiant	<input type="checkbox"/> 2mg Tablet <input type="checkbox"/> 1mg Tablet	<input type="checkbox"/> Take one tablet PO daily		
Orencia	<input type="checkbox"/> 125mg Pen <input type="checkbox"/> 250mg Vial <input type="checkbox"/> 125mg Pen Syringe	<input type="checkbox"/> <b>IV Dosage:</b> Infuse _____mg at weeks 0, 2, 4 then every 4 weeks thereafter <input type="checkbox"/> <b>SC Dosage:</b> Inject 125mg SC once a week		
Otezla	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> <b>Starter Pack:</b> Use as directed <input type="checkbox"/> <b>Maintenance Dose:</b> Take one tablet PO BID		
Prolia	<input type="checkbox"/> 60mg PFS	<input type="checkbox"/> Inject 1 syringe SC every 6 months		
<input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> <b>Loading Dose:</b> Infuse 5mg/kg at weeks 0, 2, & 6 <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse 5mg/kg every 8 weeks		
Rinvoq	<input type="checkbox"/> 15mg	<input type="checkbox"/> Take 1 tablet PO daily		
<input type="checkbox"/> Rituxan <input type="checkbox"/> Truxima	<input type="checkbox"/> 100mg Vial <input type="checkbox"/> 500mg Vial	<input type="checkbox"/> Infuse 1000mg on day 1 and day 15		

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